DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 97-03

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.253 (b)

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ Budget Neutral
b. FFY 98 $ Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A page 2
Attachment 4.19-A, Exhibit A
(entire exhibit)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 - A Exhibit A
(entire exhibit)

10. SUBJECT OF AMENDMENT:
Payment for Hospital Inpatient Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review delegated to the Commissioner
Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ron Cox

14. TITLE:
Commissioner, Department for Medicaid Services

15. DATE SUBMITTED:
3/28/97

16. RETURN TO:
Commissioner
Department for Medicaid Services
3rd Floor, CHR Bldg
275 East Main Street
Frankfort KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
3/28/97

18. DATE APPROVED:
12/21/00

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/97

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid & State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

F. Special provisions relating to payments for the period of January 1, 1997 and June 30, 1997.

(1) Effective for the period beginning on January 1, 1997 and ending on June 30, 1997 the facilities' payment rates shall be computed as being the rate in effect for January 1, 1996, with the operating and professional components of the rate indexed forward to June 30, 1997.

(2) Included in the January 1, 1997 through June 30, 1997 rate will be an add-on equal to 15% of the difference between the lesser of the operating cost per diem or the maximum operating per diem and the operating per diem as limited by the rate of increase control that is reflected on the 1996 individual rate notices.

(3) For the period of January 1, 1997, through June 30, 1997 the rate of increase control is removed from the capital component of the rate.

G. Effective July 1, 1997, the universal rate year shall be July 1 through June 30.

CABINET FOR HEALTH SERVICES

DEPARTMENT FOR MEDICAID SERVICES

MEDICAID REIMBURSEMENT MANUAL FOR HOSPITAL INPATIENT SERVICES

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621-0001

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Section 100. INTRODUCTION

A cost-related, prospective payment system for hospitals providing inpatient services for Title XIX (Medicaid) recipients, to be reimbursed under the Kentucky Medicaid Program (program) of the Department for Medicaid Services (department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives:

(1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of this care for the general public,

(2) to assure program control and cost containment consistent with the public interest, and

(3) to provide an incentive for efficient management.

Under this system, payment shall be made to hospitals on a prospectively determined basis for the total cost of inpatient care with no year-end cost settlement required. The basis of this prospective payment shall be the most recent Medicaid cost report (HCFA-2552) available as of November 1 of each year, trended to the beginning of the rate year and indexed for inflationary cost increases which may occur in the prospective year.

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In addition, a maximum upper limit shall be established on all inpatient operating costs exclusive of capital costs and professional component costs. For purposes of applying an upper limit, hospitals shall be peer grouped according to bed size with allowances made in recognition of hospitals serving a disproportionate number of poor patients. Another feature of the prospective system is a minimum occupancy factor applied to capital costs attributable to the Medicaid program.

If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited base year cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services.

The payment system is designed to provide for equitable payment levels for the various peer groups of hospitals, and will directly result in the use of rates that are reasonable and adequate for efficiently and economically operated hospitals while providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Section 101. PROSPECTIVE RATE COMPUTATION

The prospective system is based on a universal rate year which is set for all hospitals using the most recent cost report data available as of November 1 of each year, trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on unaudited data shall be revised upon receipt of the audited base year cost report from the fiscal intermediary or an independent audit firm under contract with the Department. Prospective rates include both inpatient routine and inpatient ancillary costs and shall be established taking into account the following factors:

(a) Allowable Medicaid inpatient cost and Medicaid inpatient days based on Medicare cost finding principles shall be utilized. Medicaid inpatient operating costs, excluding Medicaid inpatient capital costs and Medicaid professional component costs, shall be trended to the beginning of the rate year. The Medicaid inpatient capital cost is later used in determining a capital cost per diem. The Medicaid inpatient professional component costs shall be trended to the beginning of the rate year separately from the inpatient operating costs.

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(b) Medicaid inpatient capital costs based on Medicare cost finding principles shall be utilized except that Medicaid inpatient building and fixtures depreciation cost is defined as sixty-five (65) percent of the amount reported for building and fixtures.

(c) Allowable Medicaid inpatient operating costs, excluding those fixed costs associated with capital expenses and professional component costs, shall be increased by the hospital inflation index to project current year inpatient operating costs.

(d) A Medicaid inpatient operating cost per diem shall be computed utilizing the Medicaid inpatient operating cost and Medicaid inpatient days.

(e) An upper limit shall be established on inpatient operating costs at the weighted median inpatient cost per diem for hospitals in each peer group, except as otherwise specified in Section 102. For purposes of applying n upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings shall be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up. Peer grouping shall be based on the number of Medicaid licensed hospital beds at the time of rate setting.

(f) A Medicaid inpatient capital cost per diem shall be computed using Medicaid inpatient capital costs and Medicaid inpatient days. Allowable Medicaid capital costs shall be reduced if the minimum occupancy factors are not met by artificially increasing the occupancy factor to the minimum factor, and calculating the capital costs using this minimum occupancy factor.

1. A sixty (60) percent occupancy factor shall apply to hospitals with 100 or fewer beds.

2. A seventy-five (75) percent occupancy factor shall apply to hospitals with 101 or more beds.

(g) Allowable Medicaid professional component costs shall be increased by the inflation index (DRI/McGraw-Hill Hospital Market Index) to project current year professional component costs. A Medicaid inpatient professional component cost per diem shall be computed utilizing the Medicaid inpatient professional component costs and Medicaid inpatient days;

(h) For acute care hospitals the allowable rate growth from the prior rate year

to the new rate year shall be limited to not more than one and one-half times the Data Resources, Inc. (DRI) inflation amount for the same period; limits shall be applied by component (operating and capital cost components only); rate growth beyond the allowable amount shall be considered unallowable for rate setting purposes.

(i) The prospective inpatient rate shall be the sum of the allowable inpatient operating cost per diem, the allowable inpatient capital cost per diem, and the allowable professional component per diem.

(j) If a review or appeal decision results in the revision of a rate, any additional operating cost not included in the base year cost report shall be offset by the amount allowed for trending and indexing in the following manner:

(1) If the cost increase is incurred prior to the rate year in question, the additional operating cost shall be offset by the amount allowed for trending and indexing.

(2) If the cost increase was incurred during the rate year in question, the additional operating cost shall be offset by the amount allowed for indexing.

For the rate period beginning January 1, 1997, the rates shall be the rate in effect for January 1, 1996 with the operating and professional components of the rate indexed forward for the 1997 rate period. Additionally, there shall be an add-on to the rate, computed as fifteen (15) percent of the amount between the lessor of the operating cost per diem and the maximum operating per diem as limited by the rate of increase control (1 ½ times the DRI) that is reflected on the 1996 individual Medicaid hospital rate notices. The capital component shall not be indexed, however, the capital component of the rate shall be the amount computed for capital cost in the 1996 individual Medicaid hospital rate notices, excluding the application of the rate of increase control (1 ½ times the DRI). The indexing factor to be used for the rate setting process for the period beginning January 1, 1997 shall be the inflation factor prepared by DRI for the same period.

Section 102. ESTABLISHMENT OF UPPER LIMIT

An upper limit applicable to all inpatient costs, except capital costs and professional component costs, shall be set at the weighted median cost for hospitals in each peer group, with the exception of hospitals serving a disproportionate number of indigent patients. (See Section 102B regarding hospitals determined to meet disproportionate share requirements).

Rehabilitation hospitals and acute care hospitals providing only rehabilitation services shall be exempted from operating upper limits.

General procedures for setting the upper limit shall utilize cost reports available as of November 1 of each year for all hospitals, allowable Medicaid inpatient cost, excluding those fixed costs associated with capital expenses, and professional component cost shall be trended to the beginning of the prospective rate year. The trending factor shall be established using the Date Resources, Inc., average rate of inflation applicable to the period being trended. The trending factor thus determined shall be utilized to establish the allowable Medicaid inpatient cost basis for indexing.

The cost basis shall then be indexed for the prospective rate year to allow for projected inflation for the year. The result represents the Medicaid inpatient allowable cost basis for rate setting, which is then converted to a per diem cost

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utilizing the latest available Medicaid inpatient bed day statistics for each hospital.

For purposes of applying an upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings for this payment system shall be as follows: 0-50 beds,51-100 beds,101-200 beds, 201-400 beds, and 401 beds and up.

The hospital inpatient operating cost per diems shall be arrayed from lowest to highest by peer group. Hospitals exempted from operating limits shall not be included in the array(s). Newly constructed hospitals and newly participating hospitals shall be excluded from the arrays until a cost report that contains twelve (12) full months of data is available. The median cost per diem for each of the five (5) arrays shall be based on the median number of patient days. The upper limit for each peer group containing facilities with more than 100 beds shall be computed at the median. The upper limit for each peer group of facilities with less than 101 beds shall be 110 percent of the weighted median. The upper limit for state designated teaching hospitals shall be established at 106 percent of the weighted median per diem for hospitals in their peer group. State teaching hospitals owned or operated by the University of Kentucky and

the University of Louisville hospitals shall be removed from the array in order to set the upper limit for other hospitals in the class. These state teaching hospitals shall be subject to the upper limits for facilities with 401 beds and up

Psychiatric hospitals shall not be peer grouped, but shall be in a separate array of psychiatric hospitals only.

Except as indicated in Section 101, the operating cost per diem and the capital cost per diem shall be limited to the prior year's rate per diem increased by 150 percent of the DRI average rate of inflation.

Section 102A. PAYMENT FOR CHILDREN WITH EXCEPTIONALLY HIGH COST OR LONG LENGTHS OF STAY

(a). CHILDREN UNDER AGE ONE (1)

For medically necessary hospital inpatient services provided to infants under the age of one (1) with exceptionally high cost or long lengths of stay, the payment shall be the same as item (b) of this section. These payments shall apply without regard to length of stay or number of admissions of the infants and regardless of whether they are in a disproportionate share hospital.

(b) CHILDREN UNDER AGE SIX (6) IN A DISPROPORTIONATE SHARE HOSPITAL

For medically necessary stays in disproportionate share hospitals, the allowable length of stay for children under age six (6) shall not be limited. After thirty (30) days from the date of admission (thirty (30) days from the date of the mother's discharge in the case of newborns), the facility shall be paid a per diem equal to 110 percent of their normal per diem. During the initial thirty (30) days the hospital shall be paid its normal per diem. The payment rate shall be based on the hospital's prospective rate in effect for the period billed.

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Section 102B. DISPROPORTIONATE SHARE HOSPITALS

42 U.S.C. 1396r-4, as amended, imposed new requirements regarding payments to hospitals considered to be serving a disproportionate share of indigent individuals (i.e., the term "disproportionate share hospital"). This section of the manual specifies which hospitals shall be classified as disproportionate share, and the payment adjustment made with regard to them.

(a) Classification

(1) Disproportionate share hospitals shall be defined as those hospitals meeting the following criteria:

A. The hospital shall have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals. If the hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. Item A above shall not apply to a hospital if:

1. The inpatients are predominately individuals under eighteen (18) years of age; or

2. The hospital did not offer nonemergency obstetric services as of December 21, 1987.

C. In addition to the criteria in (A) and (B) of this section, the hospital shall have a Medicaid inpatient utilization rate of not less than one (1) percent to be considered as disproportionate share.

(b) The following upper limits and payment principles shall apply to disproportionate share hospitals:

(1) Acute care hospitals with Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of allowable Medicaid days, shall have an upper limit set at 120 percent of the weighted median per diem cost for hospitals in the array. In addition

to the per diem amount computed in this manner, the hospitals shall be paid, if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A);

(2) State university teaching hospitals having Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more Medicaid covered deliveries as compared to the total number of paid Medicaid days shall have an upper limit set at 126 percent of the weighted median per diem cost for hospitals of 401 beds or more. The pediatric teaching hospitals teaching hospitals (i.e.,the University of Kentucky Medical Center and Norton Kosair Children's Hospital) shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but not to exceed the prospective, reasonably determined uncompensated Medicaid cost to the facility. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid , if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A).

(3) Psychiatric hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for psychiatric hospitals in the array.

(4) All other disproportionate share acute care hospitals shall have their upper limit set at the weighted median per diem of the cost for hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid, if appropriate, an additional amount for services to infants under age six (6) (as shown in Section 102A).

A. Frequency of Review

Except as otherwise specified in this paragraph, classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the department, shall not be revised for that rate year except that for psychiatric hospitals not previously determined to meet disproportionate share hospital status due to failure to meet the one (1) percent minimum Medicaid occupancy requirement, the department shall also accept no more frequently than once each calendar year a patient census submitted by the

hospital showing adequate Medicaid occupancy with the subsequent classification to be effective for the balance of the calendar year.

(d) Disproportionate share hospital types shall be as follows:

(1) Type I hospitals shall be those in-state disproportionate share with 100 beds or less participating in the Medicaid program.

(2) Type II hospitals shall be those in-state disproportionate share hospitals with 101 beds or more, except for Type III and IV, participating in the Medicaid program.

(3) Type III hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid program that have been designated as State university teaching hospitals and have made a request to the Department for Medicaid Services to be designated as a Type III hospital with the request subsequently approved by the department. As part of its designation as a Type III hospital, the hospital shall agree to provide up to 100 percent of the state's share of matching funds necessary to secure federal financial participation for Medicaid disproportionate share hospital payments to be made to the hospital during the period of time the hospital is classed as a Type III hospital;

(4) Type IV hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid Program that are state-owned psychiatric hospitals.

(5) Type V hospitals shall be those out-of-state disproportionate share hospitals participating in the Medicaid program.

Section 102C. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

(a) The disproportionate share hospital payments for Type I and Type II hospitals shall be based on the cost of providing indigent care. Total disproportionate share payments to Type I and Type II hospitals for indigent care services provided during the 1997 fiscal year shall not exceed available funds; if payments cause the limits to be exceeded, all hospitals shall be adjusted proportionately. The funds shall be distributed to each qualifying hospital according to its proportion of costs to the total funds available for the year. The proportions shall be calculated by dividing the cost of each hospital's indigent care by the total cost of indigent care for all hospitals.

(b) The disproportionate share hospital payments for Type III hospitals and Type IV hospitals shall be equal to 100 percent of the cost of providing services to Medicaid patients, less the amount paid by Medicaid as usual Medicaid per diem payments, plus the cost of services to uninsured patients, less any cash payments made by the uninsured patients.

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(c) The disproportionate share hospital payments for Type V hospitals shall be one (1) dollar per Medicaid day plus an earned adjustment which is equal to ten (10) cents for each one (1) percent of Medicaid occupancy above one (1) standard deviation.

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Section 102D. PROVIDER TAXES

Provider taxes shall be considered an allowable cost with that portion attributable to Medicaid utilization included in the per diem rates.

Section 103. INFLATION FACTOR

After allowable costs have been trended to the beginning of the rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

The inflation factor index to be used in the determination of the prospective rate shall be the inflation factor prepared by Data Resources Inc., forecasting in conjunction with relative weights developed by the Health Care Financing Administration (HCFA). The forecasted index represents the average inflation rate for the year and shall have general applicability to all participating hospitals.

The forecasted index utilized by the program shall remain in effect for the prospective rate year.

Adjustments shall not be made to the prospective rate if actual inflation differs from the projected inflation index.

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